GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
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Washington DC 20002
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Sunrise Assisted Living on Connecticut Ave	5111 Conn., Ave Wash., DC 20008	May 21-22, 2009 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
Assisted Living Residence Law 13-127 Act 13-297	An Annual licensure survey was conducted on May 21-22, 2009, to determine compliance with Assisted Living Residence Law 13-127 and Act 13-297. The following deficiencies were based on record reviews, observations and interviews. The sample sizes were (11) resident records based on a census of ninety-four (94) residents and ten (10) employee records based on a census of one hundred (100) employees.		Received 7/1/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	508 **NOTICE OF RESIDENT'S RIGHTS**			
508	**An ALR shall place a copy of a document delineating the resident's right's rights, as set forth in this act, in a conspicuous location, plainly visible and easily read by resident's, staff, and visitors and provide a copy to each resident and resident's surrogate upon admission and at the time of any change to the**			

Cindy McSwain for Theresa Waters — 6/16/09
Name of Inspector — Date Issued

Facility Director/Designee — 10/28/09
Date

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	resident's status, level of care, or services available to the resident. Based on an observation on May 22, 2009 at approximately 1:30pm, it was determined the facility failed to place a copy of a document delineating the resident's right's rights, as set forth in this act, in a conspicuous location, plainly visible and easily read by resident's, staff, and visitors.	A Framed copy of the Resident rights was placed in the lobby area for visibilty to all residents, visitors, and Staff	6/18/09
	509 **ABUSE, NEGLECT AND EXPLOITATION**		
509 (c)	**(c) An ALR shall post signs that set forth the reporting requirement of this section conspicuously in the employee and public areas of the ALR.** Based on an observation on May 22, 2009 at approximately 1:30 pm, it was determined that the facility failed to post signs that set forth the reporting requirement of this section conspicuously in the employee and public areas of the ALR.	A Framed Copy was placed in the lobby and team room for all to see	6/18/09
	604 **INDIVIDUALIZED SERVICE PLANS**		

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604 (b)	**(b) The ISP shall include the services to be provided, when and how often the services will be provided and accessed.** Based on interview and record review, the agency failed to ensure the Individual Service Plan's (ISP) included the services to be provided; when and how often the services will be provided and accessed for two out of eleven Residents in the sample. The findings include: 1. Review of Resident #1's ISP dated April 15, 2009 dated, on May 21, 2009 at approximately 1:30 PM revealed Resident #1's wound care treatment was not documented on the ISP. Review of Resident #1's physician's order (POS) dated May 19, 2009, on May 21, 2009 at approximately 1:32 PM revealed Resident #1's coccyx wound was to be cleansed with saline, pated dry and skin prep was to be applied to the skin around the wound. Further review revealed silver alginate was to be applied into the wound and covered with gauze and clear film to make moisture proof. In an interview with the Licensed Practical Nursing (LPN) on May 21, 2009 at approximately 1:21 PM acknowledged the agency had not documented Resident	A Complete Audit of all residents Receiving Wound Care will be performed and all documentation will be added to the ISP. Going Forward, when an order is placed for wound care, the HCC or wellness Nurse will hand-write the information on the ISP. Resident #1 + #3 has been corrected.	6/29/09

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#1's wound care treatment on the ISP.

There was no documented evidence the wound care services to be provided was documented on the ISP.

2. Review of Resident #3's ISP dated January 28, 2009 dated, on May 21, 2009 at approximately 2:15 PM revealed Resident #3's wound care treatment was not documented on the ISP.

Review of Resident #3's POS dated May 18, 2009, on May 21, 2009 at approximately 2:16 PM revealed Resident #3's wound on the great left toe was to be treated with Silvadene cream daily.

In an interview with the LPN on May 21, 2009 at approximately 3:00 PM acknowledged the agency had not documented Resident #3's wound care treatment on the ISP.

There was no documented evidence the wound care services to be provided was documented on the ISP.

701

Staffing Standards

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701 (E6)	**Assure that there is at least one staff member within the ARL at all times who is certified in first aid and CPR.** Based on record review, it was determined that the ARL failed to ensure that 3 of 10 staff was certified in first aid and CPR. The finding includes: Review of the ALR personnel files revealed staff #3, #9, and #10 did not have current CPR and first aid certification in their personnel records.	A complete Audit of All CPR + First Aide Certificatons was performed. The community will hold 2 CAR + First Aid trainings to ensure staff are certified. 1st Class Held 6/18/09. 2nd class Scheduled For Mid July.	6/18/09.
701 (E11)	**Maintain personnel records for each employee that include document of criminal background checks, statements of health status, and documentation of the employee's communicable disease status.** Based on record review, it was determined that the ARL failed to provide documentation of current health		

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certificates for 3 of 10 staff and criminal background checks for 4 of 10 staff records reviewed.

The findings include:

Review of the ARL personnel revealed no current health certificates for staff #4 # 5 and #7. Further review of the personnel files failed to evidence criminal background checks for staff #2, #6, #8 and #9.

702

STAFF TRAINING

(a) All staff shall be properly trained and be able to demonstrate proficiency in the skills required to effectively meet the requirements of this act. Prior to date of hire, an employee must meet or possess one of the following criteria:

(1) Be certified as a nurse's aide;

(2) Be certified as a home care aide as defined in the Medicare criteria in OBBR 1987;

Based on an interview with the Business Office

Full Audit of team Number files will be conducted and all Team Numbers will have background check and Health certificates. Going forward, team numbers will not be permitted to start work without Appropriate documentation.

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	Coordinator on May 22, 2009 at approximately 2pm, it was revealed that a certified nursing assistant only had a current Maryland license. A telephone conference was conducted on June 4, 2009 at approximately 2pm with the Business Office Coordinator. She admitted that the facility has one hundred one (101) care manager fifty-four (54) of which are not a Certified Nursing Assistant or Home Health Aide and ten (10) are either licensed as a Certified Nursing Assistant or certified as a Home Health Aide in another state. **802** **MEDICAL, REHABILITATION, AND PSYCHOSOCIAL ASSESSMENT**	A Full Audit of all Direct Care Staff will be performed. Community will have only CNA/HHA working in the community as per regulations. Based on subsequent conversation with Licensing office, A deadline of 6/30/05 was issued to be in compliance. All new Team members must possess DC CNA or HHA to qualify for employment.	6/30/05
802 (b)	**(b) The ALR shall maintain resident information obtained from a standardized physician's statement approved by the Mayor...** Based on interview and record review, it was determined that the facility failed to have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for seven (7) of eleven (11) resident's in the sample. (Resident #1, Resident #2, Resident #3, Resident #6, Resident #7, Resident #10 and Resident #11)		

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	The findings include: 1. Review of Resident #1's medical assessment entitled "Physician's Report" dated April 9, 2004 on May 21, 2009 at approximately 1:32 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities. In an interview with the LPN on May 15, 2009 at approximately 1:33 PM it was acknowledged Resident #1 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities. There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities. 2. Review of Resident #2's medical assessment entitled "Physician's Report" dated November 11, 2005 on May 21, 2009 at approximately 1:45 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities. In an interview with the LPN on May 21, 2009 at	A tickler file will be used for medical, Rehab, and psycho social assessment to be current on a yearly basis. The HCC will be the process owner and maintain this system.	7/31/09

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approximately 146: PM it was acknowledged Resident #2 did not a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

3. Review of Resident #3's medical assessment entitled "Physician's Report" dated January 12, 2004 on May 21, 2009 at approximately 2:10 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the LPN on May 21, 2009 at approximately 2:20 PM it was acknowledged Resident #3 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

4. Review of Resident #6's medical assessment entitled "Physician's Report" dated August 16, 2007 on May 21, 2009 at approximately 2:55 PM revealed that the facility

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failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the LPN on May 21, 2009 at approximately 3:05 PM it was acknowledged Resident #6 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

5. Review of Resident # 7's medical assessment entitled "Physician's Report" dated November 28, 2006 on May 21, 2009 at approximately 3:00 PM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the LPN on May 21, 2009 at approximately 3:25 PM it was acknowledged Resident # 7 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the

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Mayor for Assisted Living Facilities.

6. Review of Resident # 10's medical assessment entitled "Physician's Report" dated June 23, 2005 on May 22, 2009 at approximately 10:20 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.

In an interview with the LPN on May 22, 2009 at approximately 11:25 AM it was acknowledged Resident # 10 did not have a medical, rehabilitation and psychosocial assessment on standardized forms approved by the Mayor for Assisted Living Facilities.

There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.

7. Review of Resident # 11's medical assessment entitled "Physician's Report" dated April 2, 2007 on May 22, 2009 at approximately 10:25 AM revealed that the facility failed to have a medical, rehabilitation and psychosocial assessment on a standardized form approved by the Mayor for Assisted Living Facilities.
In an interview with the LPN on May 22, 2009 at approximately 1:25 PM it was acknowledged Resident # 11 did not have a medical, rehabilitation and psychosocial assessment on standardized forms

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	approved by the Mayor for Assisted Living Facilities. There was no evidence an assessment had been documented on the standardized form approved by the Mayor for Assisted Living Facilities.			
	803 **FUNCTIONAL ASSESSMENT** **Within 30 days prior to admission, the facility shall collect, on a standardized form approved by the Mayor, the following information regarding each applicant:**			
803 (1)	**(1) Level of functioning in activities of daily living including bathing, dressing, grooming, eating, toileting, and mobility;**			
803 (2)	**(2) Level of support and intervention, including** **any special equipment and supplies, required to compensate for the individual's deficit in activities of daily living;**			
803 (3)				

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803 (4)	**(3) Current physical or psychosocial symptoms of the individual requiring monitoring, support, or other intervention by the ALR;**	The HCC will ensure that all residents will have a functional Assessment performed within 30 days prior to move in. 6/18/09
803 (5)	**(4) Capacity of the individual for making personal and healthcare related decisions;**	
803 (6)	**(5) Presence of disruptive behavior or behavior which presents a risk to the physical or emotional health and safety of self or others;**	
803 (6) (A)	**(6) Social factors, including:**	
803 (6) (B)	**(A) Significant problems with family circumstances and personal relationships;**	
803 (6) (C)	**(B) Spiritual status and needs; and**	
	(C) Ability to participate in structured and group activities and the resident's current involvement in such activities.	
	Based on interview and record review, it was determined that the facility failed to collect a functional assessment on a standardized form approved by the Mayor for seven (7) of eleven (11) resident's in the sample. (Resident #1, Resident #2, Resident #3, Resident # 6, Resident #7, Resident #10 and Resident #11)	

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The findings include:

1. Review of Resident #1's medical assessment entitled "Physician's Report" dated April 9, 2004 on May 21, 2009 at approximately 1:32 PM failed to include a functional assessment.

In an interview with the LPN on May 15, 2009 at approximately 1:33 PM it was acknowledged Resident #1 did not have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

2. Review of Resident #2's medical assessment entitled "Physician's Report" dated November 11, 2005 on May 21, 2009 at approximately 1:45 PM failed to include a functional assessment.

In an interview with the LPN on May 21, 2009 at approximately 1:46 PM it was acknowledged Resident #2 did not have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

3. Review of Resident #3's medical assessment entitled "Physician's Report" dated January 12, 2004 on May

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21, 2009 at approximately 2:10 PM failed to include a functional assessment.

In an interview with the LPN on May 21, 2009 at approximately 2:20 PM it was acknowledged Resident #3 did not have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

4. Review of Resident #6's medical assessment entitled "Physician's Report" dated August 16, 2007 on May 21, 2009 at approximately 2:55 failed to include a functional assessment.

In an interview with the LPN on May 21, 2009 at approximately 3:05 PM it was acknowledged Resident #6 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

5. Review of Resident # 7's medical assessment entitled "Physician's Report" dated November 28, 2006 on May 21, 2009 at approximately 3:00 PM failed to include a functional assessment.

In an interview with the LPN on May 21, 2009 at

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approximately 3:25 PM it was acknowledged Resident # 7 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

6. Review of Resident # 10's medical assessment entitled "Physician's Report" dated June 23, 2005 on May 22, 2009 at approximately 10:20 AM failed to include a functional assessment.

In an interview with the LPN on May 22, 2009 at approximately 11:25 AM it was acknowledged Resident # 10 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed

7. Review of Resident # 11's medical assessment entitled "Physician's Report" dated April 2, 2007 on May 22, 2009 at approximately 10:25 AM failed to include a functional assessment.

In an interview with the LPN on May 22, 2009 at approximately 1:25 PM it was acknowledged Resident # 11 did not to have a functional assessment.

There was no documented evidence that a functional assessment had been completed.

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	904 Medication Storage		
904 (a)	**(a)The ALA shall provide a secured space for medication storage with access to a sink and cold storage in the same area. Space for necessary medical supplies and equipment shall be provided.** Based on an observation on May 22, 2009, it was determined that the facility failed to provide a secured space for medication storage with access to a sink and cold storage in the same area. Space for necessary medical supplies and equipment shall be provided. The findings include: During an observation on May 22, 2009 locked medication carts were stored in unsecured hallways on several floors. The above finding was acknowledged by employee #1.	The Community will determine a location for medications to be stored with access to sink and cold storage and not in the Hallways.	7/30/09

1004

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1004 (a)	**General Building Interior** **(a) An ALR shall ensure that the interior of its facility including walls, ceiling, doors windows, equipment, and fixtures are maintained structurally sound, sanitary and good repair.** Based on observation and interview with the facility's Maintenance Coordinator, the ALR failed to maintain the interior of the facility in good repair. The findings include: 1. The wall paper in the dining room was observed hanging from the wall. 2. Papers and other materials were stored in the third floor hallway, which is a safety risk.		The Maintenance Coordinator will repair all outstanding issues with damaged wall paper throughout the community. Also Hallways will be kept free and clear of papers and materials.	6/30/05